MDR Tracking Number: M5-04-2746-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on April 26, 2004. According to the TWCC Rule 133.308 (e) dates of service 4/22/03 and 4/25/03 were received after the one-year filing deadline and therefore are not eligible for review.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, manual traction, myofascial release, electrical stimulation unattended, ultrasound, therapeutic exercises, diathermy, chiropractic manipulative treatment-spinal, hot/cold packs therapy, electrical stimulation, manual therapy technique, and therapeutic activities rendered on 4/30/03 through 11/12/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On July 26, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	MAR	EOB Denial Code	Rationale
5/8/03	97110	$35.00	$0.00	$35.00	No EOB	Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this Code in respect to one-on-one therapy were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements and MDR declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement is not recommended.

5/2/03	97250	$45.00	$0.00	$43.00	No EOB	Review of the requestors and respondent documentation revealed that neither party submitted copies of EOBs, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996 Medical Fee Guidelines. Therefore, the requestor is entitled to reimbursement in the amount of $93.00.
6/11/03	97122	$45.00	$0.00	$35.00		
6/26/03	97014	$30.00	$0.00	$15.00		
9/19/03	99080-73	$15.00	$0.00	$15.00	V	The carrier denied CPT Code 99080-73 with a V for unnecessary medical treatment based on a peer review, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. The requestor is entitled to reimbursement in the amount of $15.00.
TOTAL		$170.00	$0.00	$143.00		Reimbursement is recommended in the amount of $108.00.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service rendered on 5/2/03 through 9/19/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 8th day of October 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

July 19, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2746-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ------ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ------ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ------. The patient reported that while at work he sustained injuries to his head, neck, left shoulder, fracture to the forearm and traumatic injury to the right knee. Previously the patient had undergone a left rotator repair on 3/15/01, two arthroscopic surgeries to the right knee, and a TFCC repair and left ulnar ORIF. The patient presented to the current treating chiropractor on 7/2/02 with complaints of flare-ups and recurrent pain to the left shoulder, arm and ongoing constant right knee pain. The patient was treated with multiple physiotherapy modalities, active therapeutic exercises consisting of assistive, isometric, isotonic and resistive exercises, and treadmill. In addition to the conservative care the patient had been treated with injection therapy to the left shoulder for ongoing impingement syndrome. On 9/10/03 the patient underwent arthroscopic meniscal repair to the right knee.

Requested Services

Levels II & V established patient office visits, traction manual, myofascial release, electrical stimulation unattended, ultrasound, therapeutic exercises, diathermy, chiropractic manipulative treatment spinal 1-2 regions, hot/cold pack therapy, electrical stimulation, manual therapy technique, and therapeutic activities from 4/30/03 – 11/12/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Letter to IRO 6/14/04
2. Operative report 9/10/03
3. Orthopedic Office notes 3/27/03 – 10/26/03
4. Designated Doctor Examination 10/11/02
5. MRI report 2/7/03

Documents Submitted by Respondent:

1. Chiropractic Modality Review 4/7/03 – 12/23/03
2. Preliminary Work Hardening Therapy Review 7/8/02
3. MRI report 9/18/02
4. Chiro Med Notes 7/2/02 – 3/12/03
5. Supplemental Charting Notes 4/30/02 – 5/20/02

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his head, neck, left shoulder, fracture to the forearm and traumatic injury to the right knee on ------. The ------ chiropractor reviewer also noted that the patient had undergone surgery to the left rotator cuff, two arthroscopic surgeries to the right knee, and a TFCC repair and left ulnar ORIF. The ------ chiropractor reviewer indicated that the patient had undergone further surgery to the right knee on 9/10/03. The ------ chiropractor reviewer also indicated that pre and postoperatively the patient had been treated with conservative measures. The ------ chiropractor reviewer indicated that there was no documented improvement in this patient's pain or function from the conservative care provided. The ------ chiropractor reviewer also indicated that the treatment rendered this patient failed to provide relief to this patient or help in his return to work. Therefore, the ------ chiropractor consultant concluded that the levels II & V established patient office visits, traction manual, myofascial release, electrical stimulation unattended, ultrasound, therapeutic exercises, diathermy, chiropractic manipulative treatment spinal 1-2 regions, hot/cold pack therapy, electrical stimulation, manual therapy technique, and therapeutic activities from 4/30/03 through 11/12/03 were not medically necessary to treat this patient's condition.

Sincerely,
